# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

830 08037 182

Reg. Dist. No.

**1. PLACE OF DEATH:**
County: Harford
City or town: Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** John W Blevins

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6.(b) Name of husband or wife: Minnie Ashley Blevins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 3 - 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hrs. min. |

9. Birthplace: Jefferson Co # N.C (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

MOTHER FATHER
12. Name: Cicero Blevins
13. Birthplace: N C
14. Maiden name: Elizabeth Childress
15. Birthplace: N C

16. Informant: Wiley C Blevins
Address: Rocks, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 / 47 (month) (day) (year)
Cemetery or crematory: Oak Grove
Location: Schucks Corner, Harford Co Md
18. Funeral director: Jos. T Foster
Address: Bel Air Md

19. 9/21 19 47 Priscilla Forwood
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 20, 1947, at 1.02 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 19 47 to SEPT. 19 47 and that I last saw h.. l.. alive on SEPT. 1, 19 47

Immediate cause of death: CEREBRAL HEMORRHAGE — DURATION: IMMEDIATE

Due to: ESSENTIAL HYPERTENSION — DURATION: APPROX. 15 YRS.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robt Buttet M.D.
M. D. or other
Address: Forest Hill, Md Date signed: 9/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

C8038

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Station Hospital, Army Chemical Ctr, Md.
How long in hospital or institution? 5 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

**3.(a) FULL NAME:** Lester H. Blevins

**3.(b) Social Security Number:** 219-18-0263

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-15-1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 4 | 8 | hrs. min. |

9. Birthplace: White Top, Grayson Co, Virginia (Town, county, and state)
10. Usual occupation: Chemical Plant Operator
11. Industry or business: U. S. Government

FATHER
12. Name: Freeman Blevins
13. Birthplace: White Top, Grayson Co, Virginia

MOTHER
14. Maiden name: Martha Catherine Welch
15. Birthplace: Ash Co, North Carolina

16. Informant: John S. Blevins
Address: Darlington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27, 1947 (month) (day) (year)
Cemetery or crematory: Blevins Cemetary
Location: White Top, Grayson Co, Virginia

18. Funeral director: H. S. Bailey
Address: Darlington, Maryland

19. Sept 24 1947 (Date rec'd by registrar) Marie M Mouledale Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 23 September 1947, at 4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 September 1947, to 23 Sept 1947 and that I last saw him alive on 23 September 1947

| Immediate cause of death | DURATION |
|---|---|
| Burns, second degree entire body. | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 23 Sept 47
Where did injury occur? Army Chemical Center, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): industry
Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: William B. Marbury WILLIAM B. MARBURY, JR. Capt. M. D. or other
Address: Army Cml Ctr, Md. Date signed: 23 Sept 47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08039

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 18-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Harford
City or town: HAVRE de GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Edward Branch

**3. (b) Social Security Number** 219-07-2334

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | C. | Widowed |

6.(b) Name of husband or wife: Mary J. Dawson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1st 1868

8. AGE: Years 79 | Months 1 | Days | If less than one day: hrs. min.

9. Birthplace: Enfield N. C. (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown.

16. Informant: Carl T. Branch
Address: 14 Hanover St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 13 1947 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Near Aberdeen
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.

19. Sept. 11 1947 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 9 1947 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6-47 to Sept 9-47 and that I last saw h— alive on Sept. 9-47

| Immediate cause of death | DURATION |
|---|---|
| Cerebral vascular accident, Hypertensive cardiovascular disease | |
| Due to | |
| Due to | |
| Other conditions: Right hemiplegia, Generalized arteriosclerosis | |

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Nogueras M.D. M. D. or other
Address: Harford Mem Hosp. Date signed 9/9/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

08040

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County Harford
City or town Darrettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-8
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Harford
City or town Darrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

**3.(a) FULL NAME** John Thomas Burton

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Widower |

6.(b) Name of husband or wife Sarah E. Groas

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 27 1865 Greenwood

**8. AGE:** Years 96 Months 0 Days 5 If less than one day ... hrs. ... min.

9. Birthplace Greenwood Balto Co
(Town, county, and state)

10. Usual occupation Ennal Laborer

11. Industry or business Retired

FATHER 12. Name Thomas Cederick Burton

13. Birthplace Greenwood Baltco md

MOTHER 14. Maiden name Laura Evans

15. Birthplace not known

16. Informant Clarence E Burton

Address Darrettsville md

17. Burial, cremation, or removal. Which? Burial Date thereof Sept 30, 1947 (month) (day) (year)

Cemetery or crematory Darrettsville

Location Darrettsville md

18. Funeral director Martin E Kurtz

Address Darrettsville

19. Sept 30 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 SEPT 1947, at 11 22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 SEPT 1947, to 28 SEPT 1947

and that I last saw h. LIVING alive on 27 SEPT 1947

| Immediate cause of death | DURATION |
|---|---|
| ACUTE CORONARY DILATATION | 1 HOUR |
| Due to HYPOSTATIC PNEUMONIA | 48 HOURS |
| Due to ARTERIOSCLEROSIS | 10 YEARS |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE H. P. Sidwell M.D.
M. D. or other

Address Bel Air Md. Date signed 28 Sept 47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1572

C8041

## CERTIFICATE OF DEATH

Reg. Dist. No. 165

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 24 hrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Warren St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Kenneth Clark

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Single |

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 26 - 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hrs. min. |

9. Birthplace Havre de Grace (Town, county, and state)
10. Usual occupation none
11. Industry or business —
12. FATHER — Name Glen Clark
13. FATHER — Birthplace Magnolia Del.
14. MOTHER — Maiden name Mendena Lemmon
15. MOTHER — Birthplace Havre de Grace
16. Informant Glen Clark
Address Warren St. Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/47 (month) (day) (year)
Cemetery or crematory H. James
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace
19. Sept. 28 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1947, at 6:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1947, to Sept 28 1947
and that I last saw him alive on Sept 28 1947

| Immediate cause of death | DURATION |
|---|---|
| Congenital malformation of heart | |
| Due to | |
| Due to Cardiac Failure | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M. D. or other
Address Havre de Grace Date signed 9/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08042

1952

Reg. Dist. No. 181

**1. PLACE OF DEATH:**
County: Harford
City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Not Hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: New York County:
City or town: New York
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 312 West 120th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** JAMES W. CONEYS

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 May 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 3 | 29 | hrs. min. |

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business:

FATHER
12. Name: Joseph Coneys
13. Birthplace: Mexico

MOTHER
14. Maiden name: B'Ella
15. Birthplace: Puerto Rico

16. Informant: Ochman, Stanley P.
Address: APG, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1947 (month) (day) (year)
Cemetery or crematory: Griffin Funeral Home
Location: 2284 Seventh Ave., New York City
18. Funeral director: Howard K. McComas & Son
Address: Abingdon Maryland
19. Sept 29 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 15 Sept 19 47, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19, to 19
and that I last saw h alive on Not seen alive 19

| | DURATION |
|---|---|
| Immediate cause of death: Accidental explosion of a bomb carried on an army plane while on an official test | |
| Due to: flight | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 15 Sept 47
Where did injury occur? Aberdeen Proving Ground, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Aberdeen Pr Gr, Md.
Means of injury: see above Injured at work? Yes

23. SIGNATURE: Warren H. Brockett M.D. M. D. or other
Station Hospital, APG, Md.
Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a 08043

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 S. Washington

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Margaret Garrett Cowie

**3.(b) Social Security Number** –

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife Dr. Charles A Cowie

6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Sept. 4 - 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 0 | 22 | ...hrs. ...min. |

9. Birthplace Tennessee (Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business –

FATHER 12. Name Franklin Garrett

13. Birthplace Penn.

MOTHER 14. Maiden name Agnes M. Bond

15. Birthplace Penn.

16. Informant Col. F. H. Cowie

Address 4 Ford Hill Rd. Alexandria Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/22/47 (month) (day) (year)

Cemetery or crematory Arlington Nat'l.

Location Fort Myer Va.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. Sept. 27 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947 at 1:30 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from June 1 1947 to Sept 26 1947

and that I last saw h[illegible] alive on Sept 26 1947

| Immediate cause of death | DURATION |
|---|---|
| Fracture of Right Femur | 6 |
| Hypostatic pneumonia | |
| Due to Chronic congestion of Lungs | |
| Due to Toxemia | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/20/47

Where did injury occur? Havre de Grace (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall Injured at work? –

23. SIGNATURE Charles J. Foley M.D. or other

Address Havre de Grace Md. Date signed 9/27/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08044

1952 CB

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Harford
City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Not hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Pennsylvania County: Philadelphia
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5518 Locust Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2 ✓

**3.(a) FULL NAME:** GABRIEL JOHN DAY

**3.(b) Social Security Number:** 182-07-5894

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Anna Day
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1916

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 2 | 22 | hrs. min. |

9. Birthplace: Philadelphia, Pennsylvania (Town, county, and state)
10. Usual occupation: Photographer
11. Industry or business: U. S. Government

FATHER
12. Name: Edward Day
13. Birthplace: Italy

MOTHER
14. Maiden name: Margaret Mirra
15. Birthplace: Philadelphia, Penna.

16. Informant: Corinne Hines
Address: Civ. Pers., Aberdeen Prov Grd., Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Sept. 19 1947 (month) (day) (year)
Cemetery or crematory: Pennsylvania Burial Co
Location: 1327 South Broad St. Phila, Pa.

18. Funeral director: Howard R. McComas & Son
Address: Abingdon Maryland

19. Sept 29 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on Not seen alive 19.....

Immediate cause of death: Accidental explosion of a bomb carried on an army plane while on an official test flight — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 15 Sept 47
Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Aberdeen Prov Grd., Md
Means of injury: See above Injured at work? Yes

23. SIGNATURE: Warren H. Brackett M.D. M. D. or other
Address: Station Hospital, APG, Md. Date signed

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 8 X

08045

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: 450 Bourbon St
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 450 Bourbon St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Daisy Bainbridge Detwiler

**3.(b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Amos L. Detwiler
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 1 | 17 | hrs. min. |

9. Birthplace: Norristown, Pa. (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business

FATHER
12. Name: John Bainbridge
13. Birthplace: Penn.

MOTHER
14. Maiden name: Eliza Hill
15. Birthplace: Ga.

16. Informant: Mr. Amos L. Detwiler
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22, 1947 (month) (day) (year)
Cemetery or crematory: Norristown City Cem.
Location: Montgomery Co. Pa.

18. Funeral director: P. Madison Mitchell
Address: Havre de Grace, Md.

19. Sept. 19 1947 (Date rec'd by registrar) C. L. Lewis R.S. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 18 1947, at 9 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1946, to Sept 18 1947
and that I last saw h[illegible] alive on Sept 18 1947

| Immediate cause of death | DURATION |
|---|---|
| Cachexia | |
| Due to Carcinoma of Cervix | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 9-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08046

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5I years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 209 N. Union Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Michael William Fahey

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Margaret Hollahan Fahey

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): January 9, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 5I | 8 | 20 | ....hrs. ....min. |

9. Birthplace: Harford Co.
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business

FATHER
12. Name: John Fahey
13. Birthplace: Harford Co.

MOTHER
14. Maiden name: Mary Farrell
15. Birthplace: Harford Co.

16. Informant: Margaret H. Fahey (wife)
Address: 209 N. Union Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/2/47 (month) (day) (year)
Cemetery or crematory: Mt. Erin
Location: HavredeGrace, Md.

18. Funeral director: Pennington & Son
Address: Have de Grace, Md.

19. Oct. 1 19 47 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 19 47, at 12:00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 19 47, to Sept 29 19 47
and that I last saw him alive on Sept 29 19 47.

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | |
| Due to: Cardiac Respiratory Failure | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other

Address: Havre de Grace Md. Date signed: 10/1/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1952 MD 08047

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Not hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: North Carolina County:

City or town: Rural- Black Mountain
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** WILLIAM MAURICE FITZPATRICK

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Louise Fitzpatrick

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 10 | 19 | hrs. min. |

9. Birthplace (Town, county, and state)

10. Usual occupation: U. S. Army

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden name

MOTHER 15. Birthplace

16. Informant: Ochman, Stanley P.

Address: Aberdeen Proving Ground, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1947 (month) (day) (year)

Cemetery or crematory: Holderness South Mortuary

Location: Pine Bluff Arkansas

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md.

19. Sept 29 19 47 Nellie H. Tilley
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on Not seen alive 19

| Immediate cause of death | DURATION |
|---|---|
| Accidental explosion of a bomb carried on an Army plane while on an official test flight | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 15 Sept 47

Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Aberdeen Prov Grd., Md.

Means of injury: see above Injured at work? Yes

23. SIGNATURE: C C Howe M. D. or other

Address: Station Hospital, APG, Md. Date signed

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08048

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

**1. PLACE OF DEATH:**

County: Harford

City or town: Rural - Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred: Rocks, Md. Rural Route

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural - Federal Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Anna Mary Stansbury Foard

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: George Oliver Foard Deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 1 | 11 | hrs. min. |

9. Birthplace: Rocks, Harford Md (Town, county, and state)

10. Usual occupation: Home maker

11. Industry or business:

FATHER — 12. Name: Tobias Emerson Stansbury III

13. Birthplace: Louisianna, Ascension Parish

MOTHER — 14. Maiden name: Amanda Rutledge

15. Birthplace: Rocks, Md.

16. Informant: Mrs. Mary Foard Burton

Address: Rocks, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5 1947 (month) (day) (year)

Cemetery or crematory: Wm. Watters Memorial

Location: Cooptown, Md

18. Funeral director: Martin L. Kurtz

Address: Jarrettsville, Md.

19. Sept 5 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 3, 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1945, to September 3, 1947 and that I last saw her alive on September 3, 1947

| Immediate cause of death: Uremic poisoning | DURATION |
|---|---|
| Due to: Hypertensive cardio renal disease | |
| Due to: | |
| Other conditions: Chronic heart failure | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles A. Pratt M.D. M. D. or other

Address: Street, Md Date signed: 9-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08949

117a

BC

Reg. Diat. No. 185

**1. PLACE OF DEATH:**

County: Harford

City or town: Station Hospital, APG, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Station Hospital, APG, Md.

How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1310 Townson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

**3.(a) FULL NAME**

CLAUDE R. FORDHAM

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Francis V. Fordham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7 December 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 9 | 21 | ..... hrs. ..... min. |

9. Birthplace: Seventh Spring, N. C.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Claude M. Fordham
13. Birthplace: Lenoir County North Carolina

MOTHER
14. Maiden name: Roberta Huggins
15. Birthplace: ~~Lenoir Co~~ Wilson N.C.

16. Informant: Sgt. Alfred Pezzella
Address: APG, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/47 (month) (day) (year)

Cemetery or crematory: New National Cem.

Location: Frederick Ave.

18. Funeral director: Charles F Hill

Address: 1501 E. Fort Ave.

19. 9-30 19 47 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 September 19 47, at 1415 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1000 hrs 26 Sept 19 47, to 1415 hrs 28 Sept 19 47 and that I last saw h... im ...alive on 28 Sept 19 47

| Immediate cause of death | DURATION |
|---|---|
| Respiratory failure during anaesthesia | |
| Due to: Extreme anemia and anoxemia due to gastric hemorrhage | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: hemorrhage from gastric ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Virgil Dart M.D. Capt. M.C.
M. D. or other

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08050

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

**1. PLACE OF DEATH:**

County: Harford

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Baltimore R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Ida B Turnbaugh

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: William D. Turnbaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26 1860

8. AGE: Years: 87 | Months: 6 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER — 12. Name: John Bolton

FATHER — 13. Birthplace: Harford Co Md

MOTHER — 14. Maiden name: Sarah A DeVoe

MOTHER — 15. Birthplace: Harford Co Md

16. Informant: J Lawrence Bamford

Address: Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2 1947 (month) (day) (year)

Cemetery or crematory: St Pauls

Location: Baltimore Md

18. Funeral director: H Howard Webb

Address: Fawn Grove Pa

19. Oct 2 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1947 to Sept 29 1947 and that I last saw h... alive on Sept 29 1947

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | ? |
| Due to Arteriosclerosis | |
| Hypertension | |
| Due to Congestion of right Lung | 1 Mo. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Edward St. Hyson M. D. or other

Address: Fawn Grove, Pa. Date signed: 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08051

46b

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

**1. PLACE OF DEATH:**
County: Harford
City or town: Street, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Street, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Rosina E. Good

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | widowed |

6.(b) Name of husband or wife: Jonas Good
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 14, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 1 | 26 | ..... hrs. ..... min. |

9. Birthplace: New York state (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: James Stokes
13. Birthplace: New York state

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Thomas H. Good
Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1947 (month) (day) (year)
Cemetery or crematory: Holy Cross cemetery
Location: Pylesville, Md.

16. Funeral director: Hubert P. Harkins
Address: Delta, Pa.

19. Sept. 24 1947 (Date rec'd by registrar) M. W. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1947, at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939, to Sept 10 1947
and that I last saw h.. alive on Sept 10 1947

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma Stomach | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Ca - stomach
Date of op. Aug. 1947
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Josiah A. Hunt, M.D.
M. D. or other
Address: Delta, Pa. Date signed 9/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1248

08052

## CERTIFICATE OF DEATH

Reg. Diat. No. 186

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 15 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 St. Clair

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME** Ernest Jackson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | C. | |

6.(b) Name of husband or wife: Pearl V. Jackson

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Sept. 19-1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 0 | 3 | hrs. min. |

9. Birthplace: Havre de Grace (Town, county, and atate)

10. Usual occupation: Cook

11. Industry or business: -

FATHER

12. Name: Joseph Martin

13. Birthplace: Havre de Grace

MOTHER

14. Maiden name: Clara Jackson

15. Birthplace: Havre de Grace

16. Informant: Pearl V. Jackson

Address: 415 St. Clair St

17. Burial (Burial, cremation, or removal, which?) Date thereof 9/25/47 (month) (day) (year)

Cemetery or crematory: St. James

Location: Havre de Grace

18. Funeral director: Pennington & Son

Address: Havre de Grace

19. Sept. 24 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 22 19 47 at 8 55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 22/47 19 to Sept 22 19 47

and that I last saw him alive on Sept. 21-47 19

| Immediate cause of death | DURATION |
|---|---|
| Acute Myocardial failure | |
| Due to: Bronchopneumonia | |
| Due to: | |
| Other conditions: Cirrhosis of the liver, Acute follicular tonsilitis | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D.

Address: Harford Mem Hosp. M. D. or other

Date signed: 9/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860 08053

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 3 days.
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 1 month, 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

**3.(a) FULL NAME:** Miss Katie Jamar

**3.(b) Social Security Number**

4. Sex: F.
5. Color or race: W.
6.(a) (Single), married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1867.

8. AGE: Years: 80 Months: 1 Days: 21 If less than one day: ..... hrs. ..... min.

9. Birthplace: Port Deposit, Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Clarence Jamar
13. Birthplace: Elkton, Md

MOTHER
14. Maiden name: Henrietta Nesbitt.
15. Birthplace: West. Va.

16. Informant: Ward Abrahams
Address: Port Deposit Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24, 1947 (month) (day) (year)
Cemetery or crematory: Rodgerell Cemetery
Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Sept. 24 1947 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21st 1947 at 8 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-18-47 1947 to 9-21-47 1947 and that I last saw h... alive on 9-20-47 1947

| | DURATION |
|---|---|
| Immediate cause of death: Chronic myocarditis | |
| Arteriosclerosis | |
| Due to: Fractured left hip | |
| Due to: | |
| Other conditions: Kyphosis - Senility | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8/18/47
Where did injury occur? Port Deposit (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fall Injured at work? no 11/25/47 as.

23. SIGNATURE: John F. Noguera M.D.
M. D. or other
Address: Harford Mem. Hospital Date signed 9/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08654

# CERTIFICATE OF DEATH

Reg. Dist. No. 185

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 13 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Lamb Bayard Jenkins

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | |

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1946

8. AGE: Years — Months 9 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Elkton, Cecil Co. Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Austin Lamb Jenkins Jr.

13. Birthplace: Elkton Md.

MOTHER

14. Maiden name: Jessie L. Simpson

15. Birthplace: North East Md

16. Informant: Austin Lamb Jenkins Jr.

Address: Port Deposit Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20 1947 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Maryland

18. Funeral director: Joseph R. Grant

Address: North East Md.

19. Sept 20 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1947, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-16-47 19 to 9-17 1947 and that I last saw h. alive on 9-17-47 19

| Immediate cause of death | DURATION |
|---|---|
| Convulsive State due to | |
| Hyperpyrexia of unknown | 14 hrs. |
| Due to Origin | |
| Due to | |
| Other conditions Hypocalcemia | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Bayard Jenkins M.D. M. D. or other

Address: Port Deposit Date signed 9/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08055

932

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

**1. PLACE OF DEATH:**

County: Harford

City or town: Rural - Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED.**

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Granville Taylor Leftwich

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife: Margaret Leftwich

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1866

**8. AGE:** Years: 81 | Months: 3 | Days: 28 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Marion, Smith Co., Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Raymond C. Leftwich

Address: Aberdeen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1947 (month) (day) (year)

Cemetery or crematory: Smith's Chapel

Location: Near Churchville, Md.

18. Funeral director: Penny Tarring & Sons

Address: Aberdeen, Md.

19. 9/11 1947 (Date rec'd by registrar) Priscilla Steward Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1947, to Sept 8 1947 and that I last saw h[illegible] alive on Sept 6 1947

| Immediate cause of death | DURATION |
|---|---|
| Chr Myocardial Decrease | 2 Yrs |
| Due to | |
| Due to | |
| Other conditions Arterio-sclerotic Gangrene of foot | 3 mos |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard R Hudson M. D. or other

Address: Forest Hill Md Date signed: 9/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08056

1952

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

**1. PLACE OF DEATH:**
County: Harford
City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Not hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Texas County:
City or town: Brownsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1621 Taylor Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** JESUS LUCIO

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Mexican | Married |

6.(b) Name of husband or wife: Mary L. Lucio
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 4 | 23 | hrs. min. |

9. Birthplace (Town, county, and state)
10. Usual occupation: U. S. Army
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Ochman, Stanley P.
Address: Aberdeen Proving Ground, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1947 (month) (day) (year)
Cemetery or crematory: Mrs. Mary L. Lucio
Location: 1621 Taylor St., Brownsville Tex

18. Funeral director: Howard K. McComas & Son
Address: Abingdon Maryland

19. Sept 29 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on Not seen alive 19...

| Immediate cause of death | DURATION |
|---|---|
| Accidental explosion | |
| of a bomb carried on an Army plane | |
| while on an official test flight | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 15 Sept 47
Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Aberdeen Prov Grd, Md.
Means of injury: see above Injured at work? Yes

23. SIGNATURE: C C Harvey M. D. or other
Address: Station Hospital, APG, Md. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08057

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

## CERTIFICATE OF DEATH

Reg. Dist. No. .....

**1. PLACE OF DEATH:**

County: Harford

City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:
Station Hospital, Army Chemical Ctr., Md.

How long in hospital or institution? about 39 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of motber)

State: Maryland County: Harford

City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

**3.(a) FULL NAME:** Philip Charles Luongo

**3.(b) Social Security Number:** 219-05-8073

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Pauline Lovelace

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): 26 January 1921

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 26 | 7 | 30 | ..... hrs. ..... min. |

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Chemical Plant Worker

11. Industry or business: U. S. Government

FATHER
12. Name: Giovanni Luongo
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary Letteriello
15. Birthplace: Italy

16. Informant: Mrs. Philip C. Luongo

Address: Edgewood, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: 7225 Eastern ave Baltimore

18. Funeral director: Frank Della Noce

Address: 52 N. Morley St.

19. 9-26 1947 A. W. Fedrick
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 September 1947 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 September 1947 to 25 Sept 1947 and that I last saw him alive on 25 September 1947

| | DURATION |
|---|---|
| Immediate cause of death: Burns, thermal, second and third degree, to face, chest, abdomen, arms and legs. | |
| Due to: 2. Shock, severe, secondary to #1. | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 23 Sept 47

Where did injury occur? Army Chemical Center, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Industry

Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: William B. Marbury
WILLIAM B. MARBURY, JR. CAPT
M. D. or other

Address: Army Chemical Ctr., Md. Date signed: 25 Sept 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08058

94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

**1. PLACE OF DEATH:**
County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Malcolm W. Mitchell

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Eva G Osborn
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 16th 1882

8. AGE: Years: 65 Months: 5 Days: If less than one day: hrs. min.

9. Birthplace: Aberdeen, Harford Co., Md. (Town, County, and State)

10. Usual occupation: Farmer

11. Industry or business: Corn Canner

FATHER
12. Name: John S. Mitchell
13. Birthplace: Aberdeen Md.

MOTHER
14. Maiden name: Sara S. Todd
15. Birthplace: Aberdeen Md.

16. Informant: Mrs. Charles Oliver
Address: Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 15, 1947 (month) (day) (year)
Cemetery or crematory: Grove
Location: Aberdeen, Md.

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.

19. Sept 15 1947 (Date rec'd by registrar) Nellie F. Riley Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 12th 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1947, to Sept 12 1947
and that I last saw h... alive on Sept 12 1947

Immediate cause of death: Coronary Thrombosis — DURATION: Attack 15 min.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G B Gastrum M D
M. D. or other
Address: Aberdeen Md Date signed 9/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952 08059

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Not Hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Texas County:

City or town: San Angelo
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 527 Tulliam Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** FRANK T. MOORE

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Elizabeth Frances Moore

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): May 22, 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 3 | 24 | hrs. min. |

9. Birthplace (Town, county, and state)

10. Usual occupation: U. S. Army

11. Industry or business

FATHER 12. Name: Reggie Lee Moore

13. Birthplace: Fulton, Miss.

MOTHER 14. Maiden name: Melva Izey Boroem

15. Birthplace: Fulton, Miss.

16. Informant: Ochman, Stanley P.

Address: Aberdeen Proving Ground, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Sept. 18, 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md.

19. Sept 29 1947 (Date rec'd by registrar) Nellie F. Giles Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on Not seen alive 19

Immediate cause of death: Accidental explosion of a bomb carried on an army plane while on an official test flight — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 15 Sept 47

Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Aberdeen Prov Grd, Md.

Means of injury: see above Injured at work? Yes

23. SIGNATURE: Warren H. Brockett Jr MC
M. D. or other

Address: Station Hospital, APG, Md Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08660

4864

## CERTIFICATE OF DEATH

Reg. Diat. No. 185

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 24 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 130 S. Stokes St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Mrs. Elizabeth Nichols

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | |

6.(b) Name of husband or wife: L.S. Nichols
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12 - 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 7 | 14 | hrs. min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business

FATHER
12. Name: Gustavous Whitehead
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Mason
15. Birthplace: Maryland

16. Informant: L.S. Nichols
Address: 130 S. Stokes

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/47 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace
18. Funeral director: Pennington & Son
Address: Havre de Grace

19. Sept. 30 19 47 (Date rec'd by registrar) G. K. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26th 19 47, at 6 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25. 47 19 to Sept 26 19 47
and that I last saw h or alive on Sept. 26 - 47 19

| Immediate cause of death | DURATION |
|---|---|
| Cachexia | |
| Due to Carcinoma of Uterus | |
| Due to Carcinomatosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Nogueira M.D. M. D. or other
Address: Harford Memorial Hosp. Date signed 9/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

08861

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Not Hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Illinois County: Knox

City or town: Galesburg,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1494 Mulberry St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

**3.(a) FULL NAME**
ROBERT N. REAGOR

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Frances E. Reagor

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 21 January 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 7 | 25 | ..... hrs. ..... min. |

9. Birthplace: Galesburg, Ill.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Salida, Colorado

MOTHER
14. Maiden name: Clara N. Reagor
15. Birthplace: Knoxville, Ill.

16. Informant: Ochman, Stanley P.
Address: APG, Md.

17. Transportation
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 18, 1947
(month) (day) (year)

Cemetery or crematory: Lindburg Firth, Funeral Home

Location: Galesburgh, Ill.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md.

19. Sept 29 1947
(Date rec'd by registrar)

Nellie Z. Riley
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Sept 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on Not seen alive 19.....

Immediate cause of death: Accidental explosion of a bomb carried on an army plane while on an official test flight.

DURATION

Due to: .....

Due to: .....

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 15 Sept 47

Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Aberdeen Pr Gr, Md.

Means of injury: see above Injured at work? Yes

23. SIGNATURE: Warren H. Brock 1st Lt MC
M. D. or other

Address: Station Hospital, APG, Md. Date signed .....

M

I

K

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08662

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5M

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 11 Taft St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

**3.(a) FULL NAME:** Paul L. Register

**3.(b) Social Security Number:** 214-10-9363

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Ruby Phillips
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): December 11, 1901

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 9 | 8 | ...hrs. ...min. |

9. Birthplace: Onslow Co. N.C.
(Town, county, and state)
10. Usual occupation: Truck driver
11. Industry or business: U.S.G. Aberdeen P.G.

FATHER
12. Name: James F. Register, Sr.
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Paul L. Register
Address: # 11 Taft St. Aberdeen Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 1947 (month) (day) (year)
Cemetery or crematory: Bakers
Location: Aberdeen, Md.
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.
19. Sept. 20 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1947 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 1947 to September 19 1947 and that I last saw him alive on September 19 1947

| | DURATION |
|---|---|
| Immediate cause of death: Pulmonary Embolism | Terminal |
| Due to: Venous Thrombosis of unknown Site, not diagnosed clinically | Unknown |
| Due to: Strict bed rest, imposed because of: | |
| Other conditions: Myocardial Infarction, posterior (Include pregnancy within 3 months of death) | 10 days |

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Peter P. Rodman, M.D.
M. D. or other
Address: W. Belair Ave., Aberdeen Md. Date signed 9/19/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08663

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 7 Weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120 Post Road
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Mrs. Lena Mae Richards

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | |

6.(b) Name of husband or wife: John W. Richards
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 9 | 18 | hrs. min. |

9. Birthplace: Sussex County, Del.
(Town, county, and state)
10. Usual occupation: Housemaid
11. Industry or business

FATHER
12. Name: Joseph E. Williams
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Sarah Morris
15. Birthplace: Delaware

16. Informant: John W. Richards
Address: 120 Post Road, Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/47 (month) (day) (year)
Cemetery or crematory: Bakers
Location: Aberdeen

18. Funeral director: Pennington & Son
Address: Havre de Grace

Sept. 17 1947 (Date rec'd by registrar) H. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1947 at 10 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17 1947 to Sept. 16 1947 and that I last saw h... alive on Sept. 15th 1947

| Immediate cause of death | Chronic myocarditis | |
|---|---|---|
| Due to | Chronic osteoarthritis | |
| Due to | Pyloric spasm | |
| Other conditions | Cachexia | |

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D. M. D. or other
Address: Harford Mem. Hospital Date signed 9/16/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94 or

08064

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

**1. PLACE OF DEATH:**

County: Harford

~~City~~ or town: Bradiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Harford

~~City~~ or town: Bradiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** HARRY ROBINSON

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | widowed |

6.(b) Name of ~~husband~~ or wife: Florence S. Robinson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 14, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 6 | 16 | ..... hrs. ..... min. |

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business

FATHER — 12. Name: Joseph M. Robinson

FATHER — 13. Birthplace: Harford Co. Md.

MOTHER — 14. Maiden name: Malcolm Sandborn

MOTHER — 15. Birthplace: Harford Co. Md.

16. Informant: Arthur Robinson

Address: Bradiff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3 1947 (month) (day) (year)

Cemetery or crematory: Slateville cemetery

Location: Delta, Pa.

18. Funeral director: Herbert P. Hankins

Address: Delta, Pa.

19. Oct 2 1947 (Date rec'd by registrar) M. W. Kirk Registrar

**MEDICAL CERTIFICATION** appar

20. DATE OF DEATH: Sept. 30 1947 at 14 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Probable Coronary Occlusion — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. T. Lanier M.D. Deputy Medical Examiner M. D. or other

Address: Aberdeen, Md. Date signed 9-30-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08065

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195e

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Harford
City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Not hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pusey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

**3. (a) FULL NAME:** PAUL AUGUSTUS ST. VRAIN, Jr.

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Beulah M. St. Vrain
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 3 | 10 | ..... hrs. ..... min. |

9. Birthplace: Mexico, Missouri (Town, county, and state)
10. Usual occupation: Ordnance Dept. Engineer
11. Industry or business: U. S. Government

FATHER
12. Name: Paul A. St. Vrain, Sr.
13. Birthplace: Missouri

MOTHER
14. Maiden name: Angeline Jackman
15. Birthplace: Missouri

16. Informant: Irene Mentzer
Address: Civ. Pers., Aberdeen Prov Grd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20 1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Harford Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.

19. Sept 19 1947 (Date rec'd by registrar) Nellie F. Riley Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 15 September 1947 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on Not seen alive 19.....

| | DURATION |
|---|---|
| Immediate cause of death: Accidental explosion of a bomb carried on an Army plane while on an official test flight | |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 15 Sept 47
Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Aberdeen Prov Grd, Md.
Means of injury: see above Injured at work? Yes

23. SIGNATURE: Warren V. Brake 1st Lt MC M. D. or other
Address: Station Hospital, APG, Md. Date signed .....

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

195e 08066 181

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Not Hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Pa. County:

City or town: Phila.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 852 N. 27th St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

**3.(a) FULL NAME:** SKALSKI, JULIAN J.

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Mrs. Bernice M. Skalski

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): 2 November 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 10 | 13 | ...hrs. ...min. |

9. Birthplace: Philadelphia, Pa. (town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Michalina Skalski
15. Birthplace: Philadelphia, Pa.

16. Informant: Ochman, Stanley P.
Address: APG, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1947 (month) (day) (year)

Cemetery or crematory: M.A.Tomaszewski & Son

Location: 2728 Allegheny Ave., Phila., Pa.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md.

19. Sept 29 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Sept 1947 19..., at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on Not seen alive 19...

| Immediate cause of death | DURATION |
|---|---|
| Accidental explosion of a bomb carried on an army plane | |
| Due to: while on an official test flight | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 15 Sept 47

Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Aberdeen Pr Gr, Md.

Means of injury: see above Injured at work? Yes

23. SIGNATURE: Warren H. Brooks 1st Lt MC
M. D. or other

Address: Station Hospital, APG, Md. Date signed:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

## CERTIFICATE OF DEATH

0.8067

Reg. Dist. No. 182

**1. PLACE OF DEATH:**
County Harford
City or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Harford
City or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** James Cresap Spragg

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6.(b) Name of husband or wife Grace Duryea Spragg
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Mar 16 - 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 6 | 3 | ... hrs. ... min. |

9. Birthplace Prince George Co., Va
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name James C Spragg
13. Birthplace Cumberland, Md

MOTHER
14. Maiden name Lucy Addison
15. Birthplace Richmond, Va

16. Informant Broadnax Cameron
Address Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 / 1947 (month) (day) (year)
Cemetery or crematory St Mary's
Location Emmorton, Md
18. Funeral director Joseph T Foster
Address Bel Air, Md
19. 9/21 1947 (Date rec'd by registrar) Priscilla Forwood Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947, at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Sept 19 1947
and that I last saw h~~is~~ alive on Sept 19 1947

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 1 week |
| Cerebral arterial sclerosis with Paralysis agitans ? | Years |
| Due to end Spastic paralysis ? | 1 mo |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred O Hodous M D
M. D. or other
Address Edgewood Md Date signed 9-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. An incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08068

Reg. Dist. No. 182

**1. PLACE OF DEATH:**
County: Harford
City or town: Berkley / Darlington-R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Darlington R.D. # 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Hattie Stephens

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Clinton Stephens

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 25 - 1880

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 7 | 29 | hrs. min. |

9. Birthplace: Woodbine R.D. (Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business: —

FATHER
12. Name: James Sinclair
13. Birthplace: Woodbine R.D.

MOTHER
14. Maiden name: Phoebe McGee
15. Birthplace: Woodbine R.D.

16. Informant: Mrs. R. Pomraning
Address: Darlington R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26-1947 (month) (day) (year)
Cemetery or crematory: Pine Grove Cemetery
Location: Jerusalem Pa.

18. Funeral director: Earl B. Burgess Dom. By E.B. Burgess
Address: Red Lion Pa.

19. Sept. 24 1947 (Date rec'd by registrar) M. W. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1947, at 6.30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 16 1946, to Sept 24 1947
and that I last saw h.. alive on Sept 23 1947

Immediate cause of death: Carcinomas of throat and Bronchial — DURATION: 3 yrs

Due to: ✓

Due to: ✓

Other conditions: ✓

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. P. Snodgrass M. D. or other
Address: Darlington Md. Date signed: 9/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95 b

08069

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County Harford, (Edgewood Md.,)
City or town Army Chemical Center
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md., County Harford
City or town Army Chemical Center,
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edgewood Md.
(If rural, give LOCATION)
2.(a) If veteran, name war 1st World War

**3.(a) FULL NAME** Robert James Stewart

**3.(b) Social Security Number** 220-20-7897

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Virginia Mortimer Stewart
6.(c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.) March, 3, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 6 | 1 | ....hrs. ....min. |

9. Birthplace Glens Falls, Warren Co., N.Y. (Town, county, and state)
10. Usual occupation Chief Operating Engineer
11. Industry or business U.S. Govt.,
FATHER 12. Name Robert J. Stewart
FATHER 13. Birthplace New York.
MOTHER 14. Maiden name Etta W. Ford
MOTHER 15. Birthplace Denver Colo.
16. Informant Mrs. Virginia M. Stewart
Address Army Chemical Center, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1947 (month) (day) (year)
Cemetery or crematory Cokesbury
Location Abingdon, Harford Co., Md.
18. Funeral director Howard K. McComas & Son
Address Abingdon Maryland
19. Sept 8 1947 (Date rec'd by registrar) Marie M. Hendsdale Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 4 Sept 1947, at 11:15 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Sept 1947, to ....19....
and that I last saw h... alive on ....19....

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | instant |
| Due to Rheumatic Heart Disease | ? |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....
Autopsy results....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE William B Mearlmont Jr. M.D.
M.D. or other
Address Station Hosp Acc Md. Date signed 8 Sept 47

08070

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

118

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Harford
City or town: Dublin — Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Enroute to Harford Memorial Hospital
How long in hospital or institution? Havre de Grace, Md.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
~~City~~ or town: Street Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** HARRY D. TAYLOR

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Single |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 5 - 1878

8. AGE: Years: 69 | Months: 8 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Gilder Taylor
13. Birthplace: England

MOTHER — 14. Maiden name: Mary Adams
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Louise G. Taylor
Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20-1947 (month) (day) (year)
Cemetery or crematory: Highland cemetery
Location: Street, Md.

18. Funeral director: Hubert P. Hankins
Address: Delta, Pa.

19. Sept. 24 1947 (Date rec'd by registrar) M. W. Kirk Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 17 1947 approx at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Massive Gastric Hemorrhage | |
| Due to: Cause Undetermined | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Lamm M. D.
Co. Medical Examiner M. D. or other
Address: Aberdeen, Md. Date signed: 9/17/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08071

61

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Mrs. Ada T. Way

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | |

6.(b) Name of husband or wife: Norman Way
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 8 1901

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 9 | 10 | hrs. min. |

9. Birthplace: Rising Sun Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harvey Truman
13. Birthplace: Rising Sun, Md.

MOTHER
14. Maiden name: Anna Ewing
15. Birthplace: Md.

16. Informant: Norman Way
Address: Colora Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21, 1947 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Md.

18. Funeral director: J. C. Tyson
Address: Rising Sun Md.

19. Sept. 18 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1947 at 12 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16/47 1947 to Sept. 18/47 1947 and that I last saw h.. alive on Sept. 18. 1947 1947

| Immediate cause of death | DURATION |
|---|---|
| Diabetic coma | |
| Due to | |
| Due to Chronic glomerulo-nephritis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D.
M. D. or other
Address: Harford Mem. Hospital Date signed: 9/18/47

4:06 PM

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

195 e BC 08077 181

Reg. Dist. No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ____

Hospital, institution, or street address where death occurred: ____

How long in hospital or institution? Not hospitalized

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Virginia County: ____

City or town: South Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2811 8th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** JOHN WHITNEY

**3.(b) Social Security Number:** ____

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Virginia Fuller Whitney

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 28 January 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 7 | 23 | ____ hrs. ____ min. |

9. Birthplace (Town, county, and state): U. S. Army

10. Usual occupation: ____

11. Industry or business: ____

FATHER — 12. Name: Carl D. Whitney

FATHER — 13. Birthplace: Mt. Pleasant, Iowa.

MOTHER — 14. Maiden name: Mary Stull Whitney,

MOTHER — 15. Birthplace: Davenport, Iowa.

16. Informant: Ochman, Stanley P.

Address: Aberdeen Proving Ground, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Sept. 24, 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va.

19. Funeral director: Howard K. McComas & Son

Address: Abingdon Maryland

19. Sept 26 1947 (Date rec'd by registrar) Nellie Z. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 September 1947, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on Not seen alive 19____

Immediate cause of death: Accidental explosion of a bomb carried on an Army plane while on an official test flight — DURATION: ____

Due to: ____ — DURATION: ____

Due to: ____ — DURATION: ____

Other conditions: ____ — DURATION: ____

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 15 Sept 47

Where did injury occur? Aberdeen Proving Ground, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Aberdeen PrGr, Md.

Means of injury: see above Injured at work? Yes

23. SIGNATURE: G C Harney M. D. or other

Address: Station Hospital APG, Md. Date signed ____

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08073

195d

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 330 Wilson

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** BRENDA CAROL WILLIS

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17 - 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 9 | 26 | hrs. min. |

9. Birthplace Speedwell Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Curtis Willis

FATHER 13. Birthplace Speedwell Va.

MOTHER 14. Maiden name Margaret Chipman

MOTHER 15. Birthplace Lancaster Co. Pa.

16. Informant Curtis Willis (Father)

Address 330 Wilson St.

17. Burial Date thereof 9/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Speedwell Cem.

Location Speedwell Va.

18. Funeral director Pennington & Son

Address Havre de Grace

Sept. 13 19 47 (Date rec'd by registrar)

C. L. Lewis M. D. Registrar

**MEDICAL CERTIFICATION** approx

20. DATE OF DEATH Sept 12 19 47 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| ASPHYXIATION - Accidental | |
| Due to Aspirated Vomitus | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/12/47

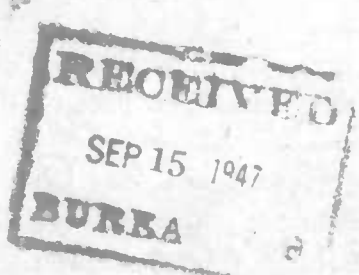
Where did injury occur? Havre de Grace (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Aspirated Vomitus Injured at work? No

23. SIGNATURE J. H. Lawney M.D.
Asst. Medical Examiner M. D. or other

Address Aberdeen, Md. Date signed 9/12/47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SEP 15 1947
BURKA

200C

MARYLAND STATE DEPARTMENT OF HEALTH BIRTH AND DEATH

# CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 181

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Harford
   City or town Aberdeen
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Station Hospital, Aberdeen Proving Ground, Md.
   Length of mother's stay in County 1 day
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER: 08812
   State New Jersey
   County Essex
   City or town Newark
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 27 Mt. Vernon Place ✓
   (If RURAL give LOCATION)

3. Name of child Bruce David Wing
4. Date of birth 16 Sept 1947 Hour 3:21 A.M.
5. Sex Male | 6. Twin or triplet
7. No. of weeks pregnancy 37

FATHER OF CHILD

8. Full name Leroy William Wing
9. Color W 10. Age at time of this birth 31 yrs.
11. Usual occupation Soldier U. S. Army

MOTHER OF CHILD

12. Full maiden name Kathleen Virginia Miller
13. Color W 14. Age at time of this birth 28 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 2

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of Apparently None
19. Labor: (a) Complications of None
    (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any None
    (c) Did child die before operation? No
    During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Unknown
    (b) Maternal causes Unknown

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature [signature] M.D.
    (Specify if M. D., midwife, or other)
    Address Sta. Hosp., APG, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 19 (month) (day) (year)
    (c) Cemetery or crematory [illegible]
24. (a) Funeral director [illegible]
    (b) Address [illegible]

25. (a) 17 Sept 47 (Date rec'd by registrar) (b) Nellie H. Riley (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

Child lived one hour

V. S. A10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08074

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 N. Union Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

**3. (a) FULL NAME** Cora Eva Woodbury

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife Preston N. Woodbury (dec'd)

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 2-1865

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 1 | 7 | hrs. min. |

9. Birthplace Louisville Ky.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business —

FATHER
12. Name ? Cooper
13. Birthplace Pennsylvania

MOTHER
14. Maiden name ? Wyle
15. Birthplace Kentucky

16. Informant Rhapsie C. Woodbury

Address 300 N. Union, Havre de Grace

17. Burial (Burial, cremation, or removal, Which?) Date thereof 9/13/47 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. Sept. 11 1947 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1947, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9, 1947, to Sept 10, 1947 and that I last saw h.. alive on Sept 9, 1947

| Immediate cause of death | DURATION |
|---|---|
| Chronic Cardio-Vascular Disease | 5 yrs. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hollweiler MD M. D. or other

Address 226 N. Union Ave., Havre-de-Grace, Md. Date signed Sept 11, 1947